29868

Testing Accommodations Appeal

Date Appeal Submitted: ☐☐/☐☐/☐☐☐☐

To be completed by Chief Examiners

Candidate's Last 4 SSN /SIN

Section 1: To be completed by GED Candidate

Dear Candidate:

You or the person who is helping you complete this form may initiate an appeal of a decision to deny any requested accommodation. Please complete this form with all of the requested information. The GED Examiner will complete Section 2. Once you complete this form, attach any additional documentation that may help with the decision process, and return this form to the GED Chief Examiner at the Official GED Testing Center where you started the accommodations process.

Last Name: _____ First Name: _____

Social Security or Social Insurance Number: ___ ___ ___ Birth Date: ☐☐/☐☐/☐☐☐☐

Address: _____

City: _____ State/Province/Territory: _____ ZIP/Postal Code: _____

Please attach a copy of your original Request for Testing Accommodations form and any additional documentation in support of your appeal.

Please describe your situation and your reasons for appealing the decision regarding your testing accommodations request. Attach additional pages if your appeal requires additional documentation.

_____

_____

Candidates' Signature: _____

Section 2: To be completed by GED Chief Examiner

Chief Examiner: _____ State/Province: _____

Center ID: _____ Center Name: _____

Phone Number: ( ) - FAX Number: ( ) -

Date Initial Testing Accommodation Request Submitted: ☐☐/☐☐/☐☐☐☐ Date of Response: ☐☐/☐☐/☐☐☐☐

Disability Type:

☐ Specific Learning Disability ☐ Attention-Deficit/Hyperactivity Disorder

☐ Physical or Chronic Health Condition ☐ Emotional or Mental Health Condition

Section 3: To be completed by Professional Diagnostician or Advocate

Please indicate your role: ☐ Professional Diagnostician ☐ Advocate

Name of Professional Making Diagnosis (please print): _____

Phone Number: ( ) - Date of Assessment: ☐☐/☐☐/☐☐☐☐

Highest Degree and Area of Specialty: _____

Licensure or Certification: State / Province: _____ Number: _____

Name of Advocate (please print): _____

Employment of Advocate (please print): _____ Education Level of Advocate (please print): _____

Professional/Advocate's Signature: _____

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Section 4: To be completed by GED Administrator

☐ Approved for:

- ☐ Extended Time (please specify): ☐ 1-1/2 times ☐ 2 times ☐ Other: _____
- ☐ Audiocassette (tone indexed) (will require extended testing time, generally double time)
  - ☐ 2 times ☐ Other: _____

  The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to the scheduled testing date.
- ☐ Braille
- ☐ Scribe
- ☐ Calculator for Part II
- ☐ Talking Calculator for Entire Mathematics Test
- ☐ Private Room
- ☐ Supervised Breaks (specify in minutes):

  Uninterrupted testing time: _____ minutes, break time: _____ minutes
- ☐ Other: _____

☐ Appeal forwarded to GEDTS for review (explain reasons below).

☐ Not approved (explain reasons below).

_____

Signature of Administrator ***Telephone Number*** ***Date***

Reasons for forwarding appeal to GEDTS for review:

Reasons for not approved:

Section 5

☐ Requested by Administrator ☐ Requested by Candidate